FORM APPROVED Bureau of Health Care Quality and Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED A. BUILDING B. WING _ NVN5238PCA 12/23/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2470 WRONDEL WAY STE 150A COMPLETE HOME HEALTH CARE

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FU REGULATORY OR LSC IDENTIFYING INFORMATION initial Comments this findings and conclusions of any investig y the Health Division shall not be construed rohibiting any criminal or civil investigations ctions or other claims for relief that may be vailable to any party under applicable feder tate or local laws. this Statement of Deficiencies was generate result of the State Relicensure survey	gation I as i,	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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y the Health Division shall not be construed rohibiting any criminal or civil investigations ctions or other claims for relief that may be vailable to any party under applicable federate or local laws. This Statement of Deficiencies was generate result of the State Relicensure survey	l as s, ral,			
result of the State Relicensure survey	ed as			
onducted in your agency on December 22 a 3, 2009. The state licensure survey was onducted at your agency by authority of Cha 49, Personal Care Agencies.				
he patient census was 10. en client records were reviewed. ive client contacts were made. even employee files were reviewed.				
he following regulatory deficiencies were fo	ound:			
ection 14.1(2) Administrator Responsibilitie	es	P 060		
ne licensee in the daily operation of the agency and shall appoint a person to exemis authority in his absence. The esponsibilities of an administrator include, without limitation: a) Employing qualified personnel and arranged their training; b) Ensuring that only trained attendants are roviding services to a client of the agency and that such services are provided in eccordance with the functional assessment of lient, the service plan established for the client and	ercise ging of the			
304 reine reservited or reciting	s, 2009. The state licensure survey was inducted at your agency by authority of Chief. Personal Care Agencies. The patient census was 10. In client records were reviewed. It is client contacts were made. It is even employee files were reviewed. It is following regulatory deficiencies were for exterior 14.1(2) Administrator Responsibilities. The administrator of an agency shall represe licensee in the daily operation of the agency and shall appoint a person to exist authority in his absence. The sponsibilities of an administrator include, thout limitation: (a) Employing qualified personnel and arranger their training; (b) Ensuring that only trained attendants are oviding services to a client of the agency and that such services are provided in accordance with the functional assessment cent,	a, 2009. The state licensure survey was inducted at your agency by authority of Chapter 19, Personal Care Agencies. The patient census was 10. In client records were reviewed. In client contacts were made. In even employee files were reviewed. In efollowing regulatory deficiencies were found: In ection 14.1(2) Administrator Responsibilities The administrator of an agency shall represent the licensee in the daily operation of the agency and shall appoint a person to exercise the authority in his absence. The sponsibilities of an administrator include, thout limitation: In employing qualified personnel and arranging of their training; In Employing that only trained attendants are coviding services to a client of the agency and that such services are provided in accordance with the functional assessment of the ent, the service plan established for the client and the oblicies and procedures of the agency;	and the state licensure survey was and the patient census was 10. In patient census was 10. In client records were reviewed. In client contacts were made. In even employee files were reviewed. In efollowing regulatory deficiencies were found: In eaction 14.1(2) Administrator Responsibilities In administrator of an agency shall represent the licensee in the daily operation of the agency and shall appoint a person to exercise is authority in his absence. The sponsibilities of an administrator include, thout limitation: In administrator of the agency in their training; In Employing qualified personnel and arranging in their training; In Employing that only trained attendants are oviding services to a client of the agency in the service of the agency; In a state of the agency in the service of the agency; In a state of the agency in the service of the agency;	a, 2009. The state licensure survey was inducted at your agency by authority of Chapter 19, Personal Care Agencies. The patient census was 10. The client records were reviewed. The even employee files were reviewed. The administrator of an agency shall represent elicensee in the daily operation of eagency and shall appoint a person to exercise a authority in his absence. The sponsibilities of an administrator include, thout limitation: The Employing qualified personnel and arranging their training; Demourable Employing trained attendants are oviding services to a client of the agency and that such services are provided in incordance with the functional assessment of the ent, easervice plan established for the client and the olicies and procedures of the agency;

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

PRINTED: 04/01/2010 FORM APPROVED Bureau of Health Care Quality and Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING NVN5238PCA 12/23/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2470 WRONDEL WAY STE 150A **COMPLETE HOME HEALTH CARE RENO. NV 89502** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) P 060 Continued From page 1 P 060 and reporting system that reflects the fiscal experience and current financial position of the agency; (d) Negotiating for services provided by contract in accordance with legal requirements and established policies of the agency; (e) Providing oversight and direction for attendants and other members of the staff of the agency as necessary to ensure that the clients of the agency receive needed services; (f) Developing and implementing policies and procedures for the agency, including, without limitation, policies and procedures concerning terminating the personal care services provided to a client: (a) Designating one or more employees of the agency to be in charge of the agency during those times when the administrator is absent; and (h) Demonstrating to the Health Division upon request that the agency has sufficient resources and the capability to satisfy the requests of each client of the agency related to the provision of the personal care services described in the service plan to the client. This STANDARD is not met as evidenced by: Based on staff interview, the agency failed to produce any evidence an accounting and reporting system that reflects the fiscal experience and current financial position of the agency.

Scope: 3

SS=F

Severity: 1

P 110 Section 15(2) Description Prohibited Activities

2. Provide descriptions of any activities that

P 110

FORM APPROVED Bureau of Health Care Quality and Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING NVN5238PCA 12/23/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2470 WRONDEL WAY STE 150A **COMPLETE HOME HEALTH CARE RENO. NV 89502** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) P 110 Continued From page 2 P 110 attendants are prohibited from engaging in. including, without limitation: (a) Making a long distance telephone call that is personal in nature: (1) On a telephone owned by or provided by a client: or (2) While on duty providing personal care services to a client; (b) Loaning, borrowing or accepting gifts of money or personal items from a client; (c) Accepting or retaining money or gratuities from a client, other than money needed for the purchase of groceries or medication for the client; and (d) Becoming the legal guardian of a client or being named as an attorney-in-fact in a power of attorney executed by the client; This STANDARD is not met as evidenced by: Based on record review and staff interview, the agency failed to include in their documentation a description of personal care activities prohibited by statute in the disclosure statement. (Client #1, 2, 3, 4, 5, 6, 7, 8, 9 and 10) The agency failed to include the following prohibitions in their Disclosure Statement, policies and procedures and employee new hire information: 2. Provide descriptions of any activities that attendants are prohibited from engaging in, including, without limitation: (a) Making a long distance telephone call that is personal in nature: (1) On a telephone owned by or provided by a client; or

(2) While on duty providing personal care

(d) Becoming the legal guardian of a client or

services to a client:

Bureau of Health Care Quality and Compliance

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C		(X2) MULTIP	PLE CONSTRUCTION	(X3) DATE SUF COMPLET			
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NAME OF PR	OVIDER OR SUPPLIER		STREET ADDRE	SS, CITY, STA	TE, ZIP CODE				
COMPLET	E HOME HEALTH CARE	i.	2470 WROND RENO, NV 89	0 WRONDEL WAY STE 150A O, NV 89502					
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P 110	Continued From page	e 3		P 110					
	being named as an ar								
	Scope: 3 Sever	rity: 2							
P 140 SS=F	Section 15(5) Infectio	us Disease		P 140					
	5. Provide for the pre- investigation of infecti diseases;	vention, control and ions and communicable	•						
	Based on review doci interview, the agency control policy that wo	failed to provide an infould provide for the and investigation of infec	ection						
	agency's standard for lack of documentation	and procedure manual, rms and interview revea n of a method for identif g and investigating infe- seases.	aled a fying,						
	Scope: 3 Seve	erity:2							
P 210 SS=C	Section 15(12) Perso	nnel Records		P 210					
	12. Provide for the mapersonnel records who policies and procedure		and						
	Based on record revie agency failed to provi	not met as evidenced b ew and staff interview, t de for the maintenance ords which confirm tha	the of						

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		NVN5238PCA		B. WING		12/23/2009	
NAME OF PR	ROVIDER OR SUPPLIER	NVN3230F CA	STREET ADD	RESS, CITY, STA	TE. ZIP CODE	12	12312009
	E HOME HEALTH CARE		2470 WROI	NDEL WAY ST			
COMPLET	E HOWE REALTH CARE	•	RENO, NV	89502			
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P 210	Continued From page	e 4		P 210			
	policies and procedur	res were being followed	I.				
	Policies and Procedu	records and the agency res revealed a lack of to be maintained in the					
	ocope : o ocventy.	. 1					
P 230	Section 16.1(a-i) Pers	sonnel File		P 230			
	kept for each attenda must include, without (a) The name, address the attendant; (b) The date on which working for the agency (c) Documentation that tests or obtained the by NAC 441A.375; (d) Evidence that the attendant were check (e) Evidence of compthe administrator of the person licensed to oprespect to the attendant (f) Proof that, within 6 began working for the attendant obtained a cardiopulmonary resultant control of the attendant obtained a cardiopulmonary resultant cardiopulmonary resultant (g) Proof that the attendant obtained in the attendant obtai	limitation: as and telephone numb at the attendant began by; at the attendant has had certificates required references supplied by ted by the agency; liance with NRS 449.17 the agency or the terate the agency with ant; the months after the attent agency, the certificate in first aid an ascitation issued by the ted Cross or an equivale by the Health Division; and by the attendant of a	er of d the the 79 by dant and ent ars of				

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If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

2. The documentation described in paragraph (i)

limitation, for each training course attended by

(a) A description of the content of the training

(b) The date on which the training course was

(c) The number of hours of the training course;(d) The name and signature of the instructor of

of subsection 1 must include, without

the attendant:

course;

attended:

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
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	NVN5238PCA IE OF PROVIDER OR SUPPLIER S		STDEET ADDI	RESS, CITY, STA	TE ZID CODE	12/2	3/2009
NAME OF PR	OVIDER OR SUPPLIER			NDEL WAY ST			
COMPLET	E HOME HEALTH CARE		RENO, NV		L 100A		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FUL LSC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETE DATE
P 240	Continued From page	e 6		P 240			
	the training course; a (e) A certificate indica was successfully com attendant.	ating that the training co	ourse				
	This STANDARD is a Based on employee finterview, the agency required documentati training certificates for (Employee #2)	failed to provide the on on the attendant's	y:				
	Severity: 1 Sco	ope: 1					
P 270 SS=E			f lity	P 270			
	Based on record revieus agency lacked docum telephone calls or vishome of clients to encare services were properties at 1, 2, 3, 4, 5, 6, 7, 8, 9 and 2, 3, 4, 5, 6, 7, 8, 9, 8, 10, 10, 10, 10, 10, 10, 10, 10, 10, 10	its by supervisory staff sure that quality person rovided to clients. (Clien nd 10)	the to the al				
	Severity: 2 Scope	e: 3					
P 420	Section 20.1(a-c) Dis	closure		P 420			
	by an agency, the ag	erson is accepted as a ency shall: disclosure statement to					

FORM APPROVED Bureau of Health Care Quality and Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED A. BUILDING B. WING ___ NVN5238PCA 12/23/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2470 WRONDEL WAY STE 150A COMPLETE HOME HEALTH CARE

COMPLETE HOME HEALTH CARE		RENO, NV 89502					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FUL REGULATORY OR LSC IDENTIFYING INFORMATIO	I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE		
P 420	Continued From page 7		P 420				
	client; (b) Require the client or a representative of the client to sign the written disclosure statement; and (c) Ensure that a copy of the written disclosure statement is incorporated into the record of the client.						
	This STANDARD is not met as evidenced by Based on record review and staff interview, the agency failed to provide a written disclosure statement to the client and ensure that a copy the written disclosure statement was in the clifle for 10 or 10 clients. (Client #1, 2, 3, 4, 5, 8, 9 and 10)	he y of lient					
	Scope: 3 Severity: 1						
P 430	Section 20.1(2) Disclosure Statement		P 430				
	2. The written disclosure statement must include a description of and information concerning the personal care services offered the agency, including, without limitation: (a) A statement which is easily understandable the client indicating that it is not within the scope of the license of the agency to mare the medical and health conditions of clients should the conditions become unstable or unpredictable; (b) The qualifications and training requirement for the attendants who provide personal care services to the clients of the agency; (c) The charges for the personal care service provided by the agency; (d) A description of billing methods, payment systems, due dates for bills for personal care	d by ele to enage ents					
	services and the policy for notifying clients of increases in the costs of personal care services.	:					

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If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Severity: 1

2. The administrator of an agency shall establish

grievances, incidents and complaints concerning the agency in accordance with the written policies and procedures of the agency. The

and enforce a procedure to respond to

Scope: 3

SS=F

P 450 Section 21.1(2) Grievance Procedure

P 450

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include, without limitation, a statement that each

(a) To receive considerate and respectful care that recognizes the inherent worth and

(b) To participate in the development of the service plan established for the client and to receive an explanation of the personal care

client has the right:

dignity of each client;

FORM APPROVED Bureau of Health Care Quality and Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING NVN5238PCA 12/23/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2470 WRONDEL WAY STE 150A **COMPLETE HOME HEALTH CARE RENO. NV 89502** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) P 480 Continued From page 10 P 480 services provided pursuant to the service plan and a copy of the service plan; (c) To receive the telephone number of the Bureau which may be contacted for complaints; (d) To receive notification of any authority of the Health Division to examine the records of the client as related to the regulation and evaluation of the agency by the Health Division; (e) To receive from the agency, within the limits set by the service plan established for the client and within the program criteria, responses to reasonable requests for assistance; and (f) To receive information, upon request, concerning the policies and procedures of the agency, including, without limitation, the policies and procedures of the agency relating to charges, reimbursements and determinations concerning service plans. This STANDARD is not met as evidenced by: Based on record review and staff interview, the agency failed to include all client rights on the documented client rights statement provided to clients at admission. The items not included on the client rights form was as follows: The telephone number of the Bureau which may be contacted for complaints; Notification of any authority of the Health Division to examine the records of the client as related to the regulation and evaluation of the agency by the Health Division; To receive from the agency, within the limits set by the service plan established for the client and within the program criteria, responses

to reasonable requests for assistance; and To receive information, upon request, concerning

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agency failed to proved documentation that included the date and signature of the person

initial screening and developed or accepted the

Review of documentation revealed that in the Initial Screening document lacked documented evidence of a place for the signature of the screener and the date it was completed.

who conducted the

service plan.

Bureau of Health Care Quality and Compliance STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING _ NVN5238PCA 12/23/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2470 WRONDEL WAY STE 150A **COMPLETE HOME HEALTH CARE RENO, NV 89502** (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) P 490 Continued From page 12 P 490 Severity: 1 Scope: 3